MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes () No
Requestor's Name and Address Edward Wolski, M.D. / Wol+Med 2436 I-35 South, Ste. 336 Denton TX 75205	MDR Tracking No.: M4-03-8646-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 27 Hartford Casualty Ins. Co. / Specialty Risk Services Po Box 4996 Syracuse NY 13221	Date of Injury: Employer's Name: Community Health Systems, Inc. Insurance Carrier's No.: 690C 33827

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
7/23/02	7/23/03	99070 (analgesic)	$13.00	$13.00
10/2/02	10/2/02	64999	$208.00	$208.00
12/20/02	12/20/02	99070 (analgesic)	$13.00	Paid.

PART III: REQUESTOR'S POSITION SUMMARY

7/29/03 "We received your request for two copies…but the information was sent with the initial submission of the TWCC60. The carrier has failed to make proper reimbursement for our charges for various service dates…1) DOS 7/23/02 – The carrier failed to respond…2) DOS 10/2/02 – The carrier…denied with PEC "F" – paid per TWCC Fee guidelines…incorrect PEC code (64999 is DOP)…Carrier failed to respond to our request for reconsideration…3) DOS 12/20/02 – The carrier denied with PEC'M' – reduction (reduced to Fair and Reasonable –paid $0.00)…The carrier failed to make any type of payment and failed to provide a reason for not paying..."

PART IV: RESPONDENT'S POSITION SUMMARY

8/8/03: Response received and reference was documented on the 'Table of Disputed Services:'

DOS 7/23/02: "Did not receive billing for this DOS, carrier has now paid fair and reasonable on 8/7/03."

DOS 10/2/02: "The listed service does not meet the criteria identified in the Fee Guideline Ground Rules or code description for reimbursement."

DOS 12/20/02: "Carrier has paid F & R plus interest 8/7/03."
Enclosed with the TWCC-60 forms from the Respondent were copies of payment made on 8/7/03:: $13.00 and $0.24 interest, but the DOS was not designated.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- On 7/16/03, MDR received the Requestor's request for reimbursement of the treatment/services rendered from 7/23/02 through 12/20/02.

- In the Respondent's response, two copies of payments were submitted dated 8/7/03: $13.00, check #00957166, and $0.24, check #00957167. According to the Respondent's response, for DOS 12/20/02, "Carrier has paid…plus interest…" Therefore, DOS 12/20/02, CPT code 99070 has been paid and is no

longer in dispute.

- The Requestor submitted convincing evidence of first submission and reconsideration of billing to the carrier prior to timely submission for MDR according to rule 133.305.

- The Respondent failed to respond to the Requestor with the first EOB and reconsideration EOB for DOS 7/23/02, CPT code 99070, in accordance with 133.307(e).
  Reimbursement recommended, amount due **$13.00**.

- The Respondent failed to respond to the Requestor's request for reconsideration for DOS 10/2/02, CPT code 64999, in accordance with 133.307(e). The first EOB response was denied incorrectly with "F" for a CPT code with MAR of DOP. Therefore reimbursement according to MFG/GI, recommended,
  Amount due: **$208.00.**

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $221.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Authorized Signature	Name	6/23/05 Date of Order

PART V: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, PO Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____